WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Senate
(Assembly, Senate or Joint)

Committee on Agriculture and Insurance (SC-AI)

File Naming Example:

Record of Comm. Proceedings ... RCP

- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

COMMITTEE NOTICES ...

- *Committee Hearings ... CH* (Public Hearing Announcements)
- **

- *Committee Reports ... CR*
- **

- *Executive Sessions ... ES*
- **

- *Record of Comm. Proceedings ... RCP*
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INFORMATION COLLECTED BY COMMITTEE CLERK FOR AND AGAINST PROPOSAL

- *Appointments ... Appt*
- **

Name:

- *Clearinghouse Rules ... CRule*
- **

- *Hearing Records ... HR* (bills and resolutions)
- **05hr_ab0764_SC-AI_pt02**

- *Miscellaneous ... Misc*
- **

WISCONSIN HOSPITAL ASSOCIATION, INC.

October 27, 2005

TO: Senate Committee on Agriculture and Insurance

FROM: Laura Leitch, Vice President and General Counsel

SUBJECT: Support for SB 393, AB 764, 765, and 766

Chairperson Kapanke and members, my name is Laura Leitch and I am General Counsel for the Wisconsin Hospital Association (WHA). Thank you for this opportunity to speak today in support of SB 393, AB 764, 765, and 766. Our 130 member hospitals appreciate your commitment to address the recent Supreme Court decisions that found Wisconsin's cap on non-economic damages unconstitutional, changed the interpretation of the statute related to the collateral source rule, and found that first year medical residents are not health care providers for purposes of the Fund. We believe these decisions will damage the unique and balanced medical liability system that this legislature created more than 10 years ago and which has served Wisconsin well.

If you work in the health care system, that is, if you struggle with recruiting physicians to rural or urban areas, if you are a rural family practice doctor who also delivers babies, or more importantly, if you are a patient who may not have access to the care you need, you know that an adequate response to the recent court decisions, to rebalance the system especially by restoring the cap on awards for pain and suffering, is crucial.

Yet, today you will hear all sorts of reasons why Wisconsin should not restore a cap on non-economic damages. Some will tell you that the damage cap made no difference in Wisconsin and that liability insurance premiums will not go up due to its loss. But you have received compelling evidence to the contrary from Pinnacle Resources, authors of the September 2005, actuarial analysis of Wisconsin's medical malpractice environment.

Some will attempt to distract you by claiming malpractice premiums are a minuscule percentage of overall health care costs. But this is not about some misleading comparison to overall health care spending -- it is about the patients put at risk when individual physicians' skyrocketing liability premiums force those physicians to leave Wisconsin or retire too soon.

The fact that malpractice premiums amount to a fraction of overall health care spending won't make much difference to the pregnant mother who has to travel 150 miles to deliver her baby because the last OB/GYN left town.

Some will tell you to ignore what happened in other states without a well-balanced medical liability system -- but what has happened in Illinois, Oregon, Washington, Nevada, Ohio, and many other states without caps simply cannot be ignored or minimized:

- In Oregon, liability premiums for family practice physicians that deliver babies have increased 332% since caps on non-economic damages were struck down in 1999. By 2002, 34% of all physicians delivering babies in Oregon had quit performing deliveries.

- In Washington, where their short-lived caps were struck down in 1988, fewer doctors are delivering babies and more women are arriving in Washington hospitals never having received prenatal care.

- In Illinois, were in 2002 uncapped non-economic damages accounted for 91% of the average jury award, OB-GYNs have fled the state, many coming to Wisconsin. Southern Illinois is devoid of neurosurgeons and without head trauma coverage.

- In Ohio, where caps were struck down in 1991 and again in 1995, a 2004 survey of physicians conducted by the Ohio Department of Insurance indicated that nearly 40% of those who responded said they had retired, or planned on retiring in the next three years due to rising insurance costs. Only 9% of the respondents were over age 64.

We cannot dismiss what has happened in these and other states, and we cannot ignore the stories from the dozens and dozens of skilled physicians who have left these states to come practice medicine in Wisconsin. In fact, you will hear from some of them today.

Frankly, we don't need to speculate, or wait and see what the impact of losing the cap will be in Wisconsin, because our members are dealing with it right now.

We have received numerous reports of how much more difficult it already has become to recruit physicians to Wisconsin, particularly to rural areas. New physicians considering practicing in Wisconsin, or those thinking of relocating here are very concerned about what has happened here and, more importantly, what will be done about it. They simply aren't buying the notion that without a cap, Wisconsin will be just fine. They have seen and experienced what has happened in other states and know that unchecked, the system can spiral out of control.

Through our own physician workforce studies (see attached), we know that even with a cap, Wisconsin is facing serious challenges to recruit and retain new physicians. We must to do everything we can to attract and keep the young doctors we will all need to care for us in the future.

Some will have you believe that Wisconsin is somehow immune from the escalating damages and increasing out of court settlements that have taken hold in states without caps. They will try to sidetrack this debate by pointing to the few Wisconsin jury verdicts in the last ten years that exceeded the then existing cap. But make no mistake, without a cap on non-economic damages, we will see more lawsuits, higher damages and, more importantly (but less noticed), higher out of court settlements – all of which add to instability within the system, increased liability premiums, and reduced access to care.

In fact, within days of court's decision, there were plaintiff's attorneys in Wisconsin doubling their pre-decision settlement demands. We don't need to speculate about the long-term negative impact of the decision – it is happening already.

Until very recently, Wisconsin had one of the most balanced, and frankly envied, medical liability systems in the country -- the sum of an equation that included three key factors – the Wisconsin Injured Patients and Families Compensation Fund, unlimited economic damages, and a cap on non-economic damages.

Indeed, on May 12, 2005, just six weeks before the court's decision, Wisconsin Commissioner of Insurance Jorge Gomez reported on the impact of 1995 Act 10 ($350,000 cap on non-economic damages plus inflation). In his report, the Commissioner described a then favorable medical liability climate, and the impact it has had on access to health care.

> *"To conclude ... Wisconsin's malpractice marketplace is stable. Insurance is available and affordable, and patients who are harmed by malpractice occurrences are fully compensated for unlimited economic losses. Tort reform of 1995, along with well regulated primary carriers and a well managed and fully funded Injured Patients & Families Compensation Fund has resulted in the stable medical malpractice environment,* ***and the availability of health care in Wisconsin."*** (emphasis added)

In the same report, again issued roughly two months before the Supreme Court overturned our cap on non-economic damages, Commissioner Gomez indicated that medical liability carriers were predicting premiums would remain roughly the same in Wisconsin over the coming year. However, he also made it very clear that, and again I quote:

> *"... rate stability could be dramatically impacted for both the Fund and primary carriers should the caps be removed and insurers face unlimited non-economic damages."*

A fair system, one that balances the rights of injured parties with the basic need for an accessible health care system, is what we had in Wisconsin, and what we must strive to restore through this legislation. A system in which liability premiums do not drive out of business, out of the state, or into retirement, the very doctors we count on the most when we need them the most.

To accomplish this, we must have a well-reasoned and rational cap on non-economic damages. A cap that is meaningful, and that is not so high that it essentially does not exist. And, a cap that does not stand alone, but rather as the key component of Wisconsin's comprehensive medical liability system – a system that already includes:

- Unlimited economic damages.
- Mandatory periodic payments.
- And, unlike any other state, guaranteed recovery of damages through mandatory $1 million/$3 million primary coverage for physicians and hospitals and mandatory participation in the Fund.

Now missing from this system is a cap on non-economic damages, which would be addressed by the legislation before you.

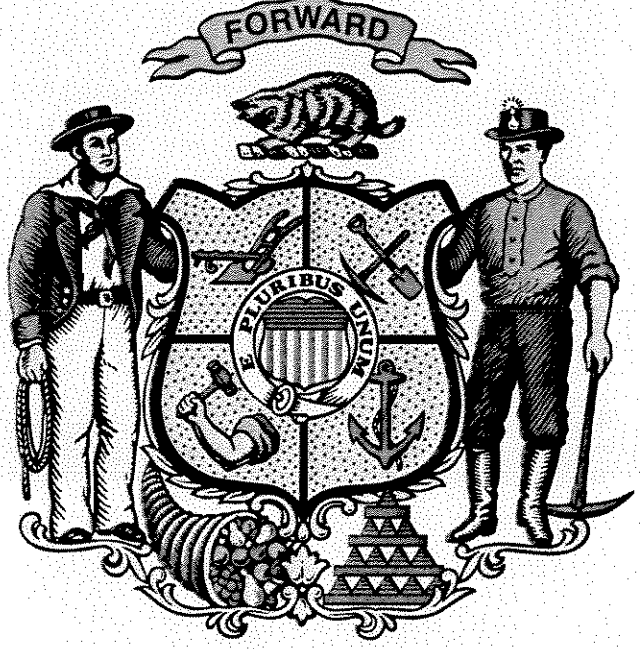
On April 7, 2005 the Illinois Hospital Association told their legislature the following:

> *"The medical liability crisis in Illinois is causing an unprecedented health care access crisis throughout the state. While some areas of Illinois may be suffering more than others, the systemic problems driving these crises exist all over Illinois and show no signs of abating. In the areas hardest hit, we are finding an absence of obstetricians willing to treat "high risk" babies, emergency care physicians unwilling to provide trauma care, and neurosurgeons refusing to provide complex and high-risk procedures."*

On August 25, 2005, after passing the Illinois Assembly and Senate, the Illinois Governor signed Illinois's new cap on non-economic damages into law.

We do not need to experience the dismantling of a health care system experienced in other states; we need to prevent it from happening.

WHA believes a balanced and equitable system can be preserved in Wisconsin but it will require the Legislature and Governor to act. We believe Wisconsin's balanced system must include a cap on non-economic damages and other important reforms, including recognition of recovery from collateral sources and Fund coverage for medical residents. We urge you to support the medical liability reform bills before you.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www.watl.org

EXECUTIVE DIRECTOR
Jane E. Garrott
44 E. Mifflin Street, Suite 103
Madison, Wisconsin 53703-2897
Telephone: 608/257-5741
Fax: 608/255-9285
Email: exec@watl.org

Testimony of David M. Skoglind

on behalf of the

Wisconsin Academy of Trial Lawyers

before the

Senate Agriculture and Insurance Committee

Senator Dan Kapanke, Chair

October 27, 2005

Good morning, Senator Kapanke and committee members. My name is David M. Skoglind. I am a partner in the Milwaukee law firm of Aiken and Scoptur. I serve as the President of the Wisconsin Academy of Trial Lawyers (WATL). On behalf of WATL, I thank you for the opportunity to appear to testify today.

Our Wisconsin Constitution grants citizens several rights – the right to trial by jury, the right to remedy, the right to due process and the right to be treated equally under the law. WATL is dedicated to preserving these very important rights for our clients. Every day our members represent people in the state of Wisconsin who need these rights protected. Courts are places where people can go to have these rights vindicated. Not the Legislative or Executive branches. Courts then serve uniquely different functions than the Legislature or Executive branches. As Senator Lindsay Graham recently remarked while discussing judicial independence, courts are places people can go that politics often won't give them access to, where the unpopular can be heard, the poor can take on the rich and the weak can take on the strong. That is why WATL is opposing 2005 SB 393 and 2005 AB 764.

There has been a lack of full participation from all interested parties. Consumer groups, injured patients and their families were completely ignored in this process, yet the legislation seeks to take away their very rights. While the legislative process shuts them out, the courts are required to listen to them. They are on equal footing with the special interests. That is not true here.

There has been a rush to judgment. The Supreme Court just threw out the last cap and the Legislature is coming back within 3-4 months with a new one. What has changed to justify it? The legislation was just introduced and now this hearing is being held and a vote likely on the floor next week. Where is the deliberation? Where is the consideration? It is a sham. We are talking about taking away the constitutional rights of our citizens and you treat it like you're voting for a national appreciation day. The Legislature has not given this issue the weight or depth of analysis it requires.

The Task Force dismissed or did not consider evidence the Supreme Court looked at when deciding the *Ferdon* case.

The Supreme Court gave the Legislature some very clear signals — if they are going to restrict the rights of Wisconsin citizens, it had better show some very good reasons and a rationale that justifies taking this extreme step. The evidence presented to the Legislature to date does not present any clear rationale that justifies a cap, especially one at such a low amount.

The bill introduced to the State Senate has a number of incorrect "findings," in our opinion. One of the findings in the bill is that a cap on noneconomic damages *"... ensures adequate compensation for victims of medical malpractice."* If one of the members of the Senate were to have a family member who is rendered quadriplegic for life as a result of medical negligence, and if the person had a life expectancy of fifty years, would that member of the Senate really think that a maximum award of $450,00 or $550,000 for noneconomic damages would be adequate compensation? It is a patently ridiculous "finding."

The bill states that the medical liability system should *limit disincentives for physicians to practice medicine in Wisconsin such as the unavailability of professional liability insurance coverage ...* The drafter of the bill has apparently forgotten that in 1975 the legislature created Wisconsin Health Care Liability Insurance Plan, a statutorily-

created insurer that was created to provide insurance to any doctor in the state, no matter what the claims experience of that doctor has been. There is no possibility that doctors will be unable to obtain liability insurance coverage in Wisconsin.

The bill also suggests that the law *help contain health care costs by limiting the incentive to practice defensive medicine*. The notion that a cap in Wisconsin would have any impact upon the hypothetical risk of defensive medicine is misplaced. Unlike some other states, a doctor in Wisconsin who complies with the statutory requirements of having primary insurance coverage and coverage with the Injured Patients and Families Compensation Fund will never have to pay a penny out of his or her pocket, either by way of settlement or judgment. Wisconsin law does not allow that to occur. The primary carrier and the fund provide first dollar coverage, up to the extent of the fund assets, now about $750 million. What difference, then, would a cap make in whether a doctor does or does not order a certain diagnostic procedure? If the patient is injured and may obtain a maximum of $450,000 in noneconomic damages, will the doctor forego ordering the diagnostic test, but if the patient might recover $1 million, the doctor would order the test? It does not make sense.

Further, the whole notion of defensive medicine is misplaced. Are doctors really saying that they order unnecessary tests because caps are not in place? The fact is that insurance companies and Medicare look over bills to make sure that diagnostic tests are indicated. If not, the bills do not get paid. The notion that doctors are dishonestly performing unnecessary tests does not say a lot for the integrity of medical professionals.

The reality regarding defensive medicine is that it does not happen, in my experience. The Shay Maurin case exemplifies that. The evidence was that the cost to Hartford Hospital of performing a finger-stick blood sugar test would have been something like 57 cents. The test was not ordered. Five-year-old Shay Maurin died.

Or the case of a man who died at age 32 from a pulmonary embolism. He went to the clinic three times in twelve days complaining of the classic signs of a pulmonary embolism, including significant and worsening shortness of breath. He told the nurse practitioner who saw him that people thought that he had a blood clot in his leg, which the autopsy showed that he had. That blood clot, called a deep vein thrombosis, was the

precursor to the pulmonary embolism. No diagnostic tests were ordered, other than a chest x-ray and blood work. The man is survived by a widow and three young children. What the people in Wisconsin need is a little more diagnostic testing, when indicated, not less.

The bill discusses the "financial integrity of the Injured Patients and Families Compensation Fund." The Fund assets have been growing by leaps and bounds. In the thirty years of fund existence, the Fund has grown to $750 million, exceeding, by far, the total compensation that has been paid to injured patients during the thirty years of Fund's existence. The Commissioner of Insurance, Jorge Gomez, testified that, "Wisconsin, ... probably has the most sound and functional malpractice environment in the country. ... Wisconsin is by far in a much better position than any other state that has a non-problem at the moment with their malpractice environments. ... And Wisconsin will not be [in a state in crisis] any time in the future, regardless of what your committee or the legislature decides on the issues of caps.... The reality is that the marketplace is competitive, the Fund is solvent, and we'll likely make adjustments based on the court's decision on assessment in the future."

That hardly appears like justification for a cap.

The testimony from Physicians Insurance Company of Wisconsin (PIC), the state's largest medical malpractice insurer, indicated there was no impending crisis and that the worst-case scenario resulting from the cap's repeal would be "single-digit" premium increases for Wisconsin doctors. In addition, PIC spoke of Wisconsin's "common sense" exercised by juries. Again we had only nine cases that were affected by the cap from 1995-2005, hardly a pressing problem.

Yes, I heard much hand wringing about "potential" problems, particularly access to physicians in rural areas. That problem existed before 1995. If the 1995 cap did not solve this problem, what evidence is there that a new cap will solve it?

Whatever the objective is for a cap, the evidence — doctors fleeing or lower malpractice insurance premiums —is merely "speculative," which the Court held could not support the constitutionality of the cap.

How can the cap be justified? It is less than $5,000 above the cap that was just determined to be unconstitutional. Where did the numbers come from? It again appears that it was picked out of the air.

The caps continue to discriminate against the most severely injured, the legislature has not remotely considered their rights in this bill and it continues to treat families unfairly, a point that was brought up in the *Ferdon* opinion.

The Ferdons' challenged the cap's reduction because the law did not treat them equally. The Supreme Court took this challenge very seriously. In a scholarly, exhaustive and well-reasoned opinion, the Court reviewed the legislative purpose of the 1995 cap as well as evidence to support and refute it. The Court reviewed over 50 reports and articles.

I would like to highlight the evidence against the caps.

Medical malpractice insurance premiums are an exceedingly small portion of overall health care costs. In Wisconsin, they are now less than 40 cents out of every $100 dollars spent on health care and it is a declining proportion. *Expansion Magazine* has rated Wisconsin's malpractice costs as the lowest in the nation. Meanwhile, Wisconsin health insurance premiums are rated second highest in the nation. There is no correlation between malpractice costs and health care costs.

The Court found that "even if the $350,000 cap on noneconomic damages would reduce medical malpractice insurance premiums, this reduction would have no effect on consumer's health care costs." That certainly proved true under the $350,000 cap. Did anyone experience lower health care costs since 1995? The Court concluded, "Accordingly, there is no objectively reasonable basis to conclude that the $350,000 cap justifies placing such a harsh burden on the most severely injured medical malpractice victims, many of whom are children."

Just nine (9) jury verdicts were impacted by the cap from 1995-2005. Below is a summary of the case and how the cap impacted the injured patients and their families.

Jury Verdict Date, County, Case #	Injured Patient and Age	Nature of injury	Noneconomic damages jury awarded, including pain and suffering	Final award	Percentage Reduced
April 2005 Milwaukee 2003CV3456	Joseph Richard mid-50's	He underwent an unnecessary removal of his rectum, with a leak of the anastomosis, ten further surgeries, and permanent bowel problems.	$540,000	$432,352	20%
May 2004 Marinette 2002CV60	David Zak mid-30s	Failure to diagnose suspicious infection causing body to shut down resulting in loss of bodily function	$1 million	$422,632	57%
April 2004 Kenosha 2001CV1261	Estate of Helen Bartholomew Early 60s	Failure to diagnose heart attack causing massive heart and brain damage requiring her to live in nursing home and resulting in her death 3 years later	$1.2 million	$350,000	70%
Dec. 2003 Ozaukee 1999CV360	Sean Kaul infant	Negligent failure to provide timely and proper treatment for hypoglyceminia and hypovolemia that developed shortly after birth rendered child permanently disabled	$930,000	$422,632	55%
Dec. 2002 Brown 2001CV1897	Matthew Ferdon infant	Negligent delivery resulting in right arm being deformed and partially paralyzed	$700,000	$410,322	40%
June 2002 Dane 2000CV1715	Scott Dickinson mid-30s	Negligent treatment during a psychotic episode and rendered a quadriplegic.	$6.5 million	$410,322	93%
June 2001 Eau Claire 2000CV120	Kristopher Brown 16 years old	Negligent treatment of a broken leg resulting in part of the leg being amputated	$1.35 million	$404,657	67%
March 2000 Eau Claire 1998CV508	Bonnie Richards Early 40s	Common bile duct clipped during laproscopic cholecystectomy resulting in residual hernias requiring additional surgeries and almost dying twice.	$660,000	$381,428	41%
October 1999 Portage 1998CV169	Candice Sheppard mid-20s	Negligent surgery to remove a cyst in the vaginal area resulted in permanent pain and injury	$700,000	$350,000	50%

These nine cases show a reduction of approximately $10.2 million from what the juries determined the damages to be after hearing all the evidence compared to the damages available under the cap enacted in 1995. That's about $1 million per year. That comes to 18 cents per person in Wisconsin per year. Furthermore, because an injured patient shares the cap with family members, the cap has a disparate effect on patients with families. It is these injured patients and their families who are bearing the total burden if medical malpractice occurs and a jury awards more than the cap. Why is it fair to burden the most seriously injured while providing monetary relief to health care providers and their insurers?

The data from the National Practitioner Data Bank, to which all payments to people injured by medical negligence must be reported, show that Wisconsin was the third lowest state for the number of payments per 1,000 doctors in 2003, the same ranking we held in both 1994 and 1995, before the cap on damages took effect.

With a cap, the Fund's enormous assets are denied to patients for whom juries have awarded compensation above the cap. In the last 10 years, the Fund's assets have almost tripled, increasing an average of $47 million a year to almost $750 million. During the same period, the Fund was only drawn upon an average of 19 times per year and payments made to families averaged only $28.5 million per year. *That amounts to $18.5 million less than the average annual increase in Fund assets.* Meanwhile, the Fund's assets, while barely tapped by injured patients, have been utilized to reduce Fund malpractice fees for doctors. Fund fees have been cut six of the last seven years, most recently by 30 percent. *The Fund fees for 2005-2006 are more than 50% lower than fees from 1986-87.*

Injured Patients & Families Compensation Fund

Year	Number of Cases Paid	Losses Paid to Injured Patient & Families
1994-95	25	$24,098,896
1995-96	28	$51,456,670
1996-97	16	$34,679,277
1997-98	24	$18,718,458
1998-99	28	$19,929,978
1999-2000	12	$19,657,326
2000-01	22	$39,636,276
2001-02	14	$35,304,773
2002-03	11	$22,074,552
2003-04	13	$19,496,969
Total	**193**	**$285,053,175.00**
Average	**19.3**	**$28,505,318**

WATL believes that grossly inaccurate actuarial projections have fueled the need for a cap. In 1995, sponsors of the cap legislation used the inaccurate projections by actuaries as a reason to impose the noneconomic damages cap. Legislators were told there was a *$67.9 million projected actuarial deficit* as of June 30, 1994. Instead, the actuaries now estimate there was a *$120 million actuarial surplus*. ***It shows that when the Legislature acted in 1995, it was given estimates that were off by almost $188 million!!*** As the Supreme Court it didn't seem to make any difference if there was or wasn't a cap because the Fund has flourished both with and without a cap.

In Wisconsin, few medical malpractice claims are filed. In a state with 5.5 million people, with millions of doctor-patient contacts yearly, only 240 medical negligence claims were filed in 2004 with the Medical Mediation Panels. That is one claim for every 22,916 Wisconsin citizens. The number has been steadily decreasing since the mid-80s. This pattern suggests that even when there was no cap on damages from 1991-1995, there was no corresponding explosion of claims. In fact, there was a decline in filings. So, the imposition of a cap is simply an additional, but wholly arbitrary, barrier to justice for most families.

Year	Medical Mediation Claims Filed	Amount of Cap*
1986	***	$1,000,000
1987	398	$1,030,000
1988	353	$1,070,170
1989	339	$1,123,678
1990	348	$1,179,862
Total	**1438**	
Average	**359.5**	
1991	338	No Cap
1992	313	No Cap
1993	276	No Cap
1994	292	No Cap
Total	**1219**	
Average	**304.75**	
1995	324	$350,000
1996	244	$359,800
1997	240	$369,874
1998	305	$375,052
1999	309	$381,428
2000	280	$392,871
2001	249	$404,657
2002	264	$410,322
2003	247	$422,632
2004	240	$432,352
Total	**2702**	
Average	**270.2**	

** The $1 million cap went into effect on June 15, 1986 and the cap was indexed on that day each year. The $350,000 cap went into effect on May 25, 1995 an was indexed each year on May 15.*
**** No numbers for that year.*

One of the most persistent assertions about caps is that they would hold down malpractice premiums for doctors. The Court analyzed several studies and found that "according to a General Accounting Office report, differences in both premiums and claims payments are affected by multiple factors in addition to damage caps, including state premium rate regulation, level of competition among insurers, and interest rates and income returns that affect insurers' investment returns. Thus, the General Accounting Office concluded that it could not determine the

extent to which differences among states in premium rates and claims payments were attributed to damage caps or to additional factors. For example, Minnesota, which has no caps on damages, has relatively low growth in premium rates and claims payments. "

In fact if you listened to the insurance companies own executives, they would not promise any savings from caps. This was recently highlighted in Illinois. In a recent news article it was reported, "As for caps on awards resulting in reduced rates for malpractice insurance premiums that doctors must pay, supporters of caps say they can't promise the new caps will significantly lower insurance rates.

Ed Murnane, the leading tort reform advocate in Illinois, said at a tort reform summit in mid-May, 'No, we've never promised that caps will lower insurance premiums.'"

Insurance execs speak up

"We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." Sherman Joyce, President of the American Tort Reform Association, (Source: "Study Finds No Link Between Tort Reforms and Insurance Rates," *Liability Week*, July 19, 1999.)

"Insurers never promised that tort reform would achieve specific premium savings . . ." (Source: March 13, 2002 press release by the American Insurance Association (AIA).)

"[A]ny limitations placed on the judicial system will have no immediate effect on the cost of liability insurance for health care providers." (Source: "Final Report of the Insurance Availability and Medical Malpractice Industry Committee," a bi-partisan committee of the West Virginia Legislature, issued January 7, 2003.)

An internal document citing a study written by Florida insurers regarding that state's omnibus tort "reform" law of 1986 said that ***"The conclusion of the study is that the noneconomic cap . . . [and other tort 'reforms'] will produce little or no savings to the tort system as it pertains to medical malpractice."*** (Source: "Medical Professional Liability, State of Florida," St. Paul Fire and Marine Insurance Company, St. Paul Mercury Insurance Company.)

This theme was further bolstered by a recent rate filing by GE Medical Protective, which sought a 19% rate increase just one year after Texas voters narrowly approved a $250,000 cap on non-economic damages in medical malpractice cases. After claiming that caps would reduce malpractice premiums, the insurer admitted in its rate-filing request that "capping non-economic damages will show loss savings of 1%."

Further, we must agree with the Supreme Court that, "Victims of medical malpractice with valid and substantial claims do not seem to be the source of increased premiums for medical malpractice insurance, yet the $350,000 cap on noneconomic damages requires that they bear the burden by being deprived of full tort compensation."

Various new studies have been released to bolster this statement. In Texas, researchers looking at Texas found that soaring malpractice premiums were not correlated with malpractice lawsuits and settlements. A team of legal scholars from the University of Texas, Illinois, and Columbia examined all closed claim cases from 1988 to 2002. The law professors found that claims rates, payments and jury verdicts were roughly constant after adjusting for inflation and concluded that the premium increases starting in 1999 "were not driven primarily by increases in claims, jury verdicts, or payouts. In the future, malpractice reform advocates should consider whether insurance market dynamics are responsible for premium hikes."

A second comprehensive study of medical malpractice claims, this time in Florida, also shows no sharp increase in lawsuits relative to population growth and a modest increase in the size of settlements. "When we compared the number of malpractice cases to the population in Florida," said Neil Vidmar, one of the study's authors and professor at Duke's School of Law, "there has been no (large) increase in medical malpractice lawsuits in Florida." Vidmar said rising health-care costs and more serious injuries resulting in larger claims or litigated payments caused the increase in the claim total. Finally, the report concludes the "vast majority of million-dollar awards were settled around the negotiation table rather than in the jury room." Of the 831 million-dollar awards reported since 1990, 63 were awarded by juries. The rest occurred as settlements.

The National Bureau of Economic Research study reviewed the relationship between the growth of malpractice costs and the delivery of health care in three areas: (1) the effect of malpractice payments on medical malpractice premiums, (2) the effect of increases in malpractice liability to physicians closing their practices or moving and (3) defensive medicine. The study found a weak relationship between medical malpractice payments and malpractice premium increases.

A July 7, 2005, study released by Center for Justice and Democracy finds that net claims for medical malpractice paid by 15 leading insurance companies have remained flat over last five years.

Meanwhile, net premiums have surged ***120 percent.*** During the 2000-04 period, the increase in premiums collected by leading 15 medical malpractice insurance companies was ***21 times*** the increase in claims they paid. The study shows an "overall surge in malpractice premiums with no corresponding surge in claim payments during the last five years."

Other key highlights of the study:

- "Over the last five years, the amount the major medical malpractice insurers have collected in premiums more than doubled, while their claims remained essentially flat."
- "...In 2004, the leading medical malpractice insurers took in approximately three times as much in premiums as they paid out in claims."
- "{T}he surplus the leading insurers now hold is almost double the amount the National Association of Insurance Commissioners deems adequate for those insurers."

Wisconsin Unique System: The Injured Patients and Families Compensation Fund

A short history of the Injured Patients and Families Compensation Fund may be in order since it has figured so prominently in the discussion of Wisconsin's malpractice system. Wisconsin's medical malpractice insurance structure was set up in 1975 to deal with a serious problem in availability of medical malpractice insurance. The Legislature guaranteed the availability of insurance by creating the Wisconsin Health Care Liability Insurance Plan (WHCLIP) as a risk-sharing plan to provide primary insurance coverage and by creating the Patients Compensation Fund (the Fund) to pay claims in excess of primary coverage. (The Legislature changed the Fund's name in 2003 to the Injured Patients and Families Compensation Fund. 2003 WI Act 111.) The same Board of Governors governs both.

The 1975 Statutory Scheme

The statutory scheme is unique: insurance is mandatory for physicians (except government-employed) and hospitals; primary coverage is from WHCLIP or a private company; the Fund fees are also mandatory and provide unlimited coverage over the primary level.

WHCLIP is run like an insurance company; the Fund is not. Fund fees were originally calculated as a percentage, not to exceed 10%, of the WHCLIP rates. Fees were to be reduced if "additional fees would not be necessary to maintain the Fund at $10 million."

The 1975 legislation contained a potential limitation on payouts. Wis. Stat. § 655.27(6) initially provided,

> If, at any time after July 1, 1978 the commissioner finds that the amount of money in the Fund has fallen below $2,500,000 level in any one year or below a $6,000,000 level for any 2 consecutive years, an automatic limitation on awards of $500,000 for any one injury or death on account of malpractice shall take effect. ... This subsection does not apply to any payments for medical expenses.

In March 1980, the law was changed to require an annual report for the Fund, prepared according to generally accepted actuarial principles, that would give the present value of all claims reserves and all

Timeline of the Fund

1975 — Legislature establishes Patients Compensation Fund (Fund) and the Wisconsin Health Care Liability Insurance Plan (WHCLIP). The legislation required that all physicians carry malpractice insurance either from a private insurer or WHCLIP for up to $200,000 and then mandates participation in the Fund, which provides unlimited coverage and pays claims in excess of primary coverage. The same 13-member Board of Governors governs both. WHCLIP is run like an insurance company; the Fund is not. Fund fees were originally calculated as a percentage, not to exceed 10%, of the WHCLIP rates and the Fund was not to have more than $10 million in assets.

1980 —The fiscal nature of the Fund was changed to give the present value of all claims reserves and all incurred but not reported (IBNR) claims. IBNR claims are claims that are not presently known but are presumed to exist. This changed the Fund from a form of "pay as you go" system to a system with a potential surplus or deficit.

1986 — The Legislature adopts an indexed $1 million cap on pain and suffering. The Fund also collapsed the number of Fund classes from 9 to 4 for purposes of calculating fees.

1987 — Doctors' primary coverage increased to $300,000.

1988 — Doctors' primary coverage increased to $400,000

1991 — $1 million indexed cap sunsets.

1995 — $350,000 indexed cap adopted.

1997 — Doctors' primary coverage increased to $1,000,000.

2003 — Fund name changed to Injured Patients and Families Compensation Fund.

incurred but not reported (IBNR) claims. IBNR claims are those claims that are not presently known but are presumed to exist; they have played an important role in the Fund's financial situation ever since 1980.

The net effect of this statutory change was to change the Fund from a form of "pay as you go" system to a system with a potential surplus or deficit based on the annual actuarial reports. The potential surplus or deficit relied heavily on the projected value of claims reserves and IBNR claims.

The Fund was established to pay claims in excess of primary coverage. Health care providers are required to purchase primary coverage — $200,000 in 1975, $300,000 in 1987, $400,000 in 1988, and $1,000,000 in 1997. Fees assessed against all health care providers in the state pay for the Fund. The Fund fees are created by administrative rule, providing the Legislature with oversight authority. The Fund is divided into no more than four

The 1986 Legislative Changes

In the early and mid-80s, was a sudden and dramatic requests for premium and fee increases. This led to a second "crisis" in medical malpractice insurance. Because WHCLIP and the Fund mechanisms worked as intended, Wisconsin did not have problems with *availability* of insurance as it had in 1975. Instead, Wisconsin suffered an "*affordability* crisis," that is; the dramatic price increases made insurance premiums and Fund fees less affordable.

The highest Fund fee increase suggested by the actuaries was a 160% fee increase for 1985-86; more than half of the increase was meant to offset a portion of the actuarial deficit. The Legislature would not go along with that huge increase but did approve a 90% fee increase.

The increased cost of medical malpractice insurance led health care providers to lobby the Legislature for strong tort "reform" measures, including caps on damages, limits on the attorneys fees of injured consumers, and limits on payments for future medical expenses. After much debate, the Legislature made numerous changes to the law in 1986 including a cap of $1 million on all noneconomic damages. The legislation, however, made few changes to directly address the elimination of the Fund's actuarial

deficit. Nevertheless, Fund fees were only moderately increased from 1986 through 1994. There was virtually no impact on fees after the noneconomic damage cap sunset on December 31, 1990 (resulting in no cap being in effect).

In addition, during the 1980s, the Fund collapsed the number of classes from nine to four, thereby moderating costs between general practitioners (Class 1) and neurologists and OB-GYNS (Class 4).

The establishment of the Fund represented an egalitarian reform that involved *sharing of risk* among all providers to hold down malpractice rates. Consequently, the Fund's premium structure divided the medical profession into just four categories, resulting in substantially lower rates for higher-risk specialties and somewhat higher rates for lower-risk categories. This sharing of risk helps Wisconsin to retain doctors in high-risk specialties upon whom general practitioners can rely for referring patients in need of more specialized care.

In sharp contrast, the cap on pain and suffering imposed a *shift of risk* from providers as a whole to patients and the public. Patients could no longer count on the legal system to give them full compensation for the pain and suffering caused by medical negligence. Juries were deprived of the power to fully compensate injured patients.

Moreover, it is precisely the Fund's unique and progressive features—not the cap—that have actually accounted for the decreases in malpractice premiums:

a) **Non-profit:** The Fund is not-for-profit. In contrast to private insurance corporations characterized by huge executive salaries, massive bureaucracies, and wild swings in premium rates contingent on stock and bond

How Wisconsin doctors are insured against malpractice

Nature of malpractice claim	Source of insurance	Premiums
For claims up to $1 million	Private insurers	Set by insurance firms, highly dependent on stock and bond investments
For claims up to $1 million when private insurance is not available	WHCLIP (serves only 2.3% of doctors)	Rates are set by the Board, and are set higher than other private malpractice insurance
For claims above $1 million	Injured Patients and Families Compensation Fund	Set by Fund Board. Fees have been cut to sub-1986 levels.

market investments, the Fund does not subject Wisconsin medical providers to these burdens.

b) **Universal:** The Fund is universal, covering virtually all health care providers in the state. Thus, the Fund draws upon a large pool of doctors to share the risk and hold down costs.

c) **Sharing the risk:** The Fund spreads the cost of insuring against risk across interrelated medical professions, so that high-risk specialties do not bear an inordinately heavy burden.

Because the Fund has been so successful at accumulating assets — almost $750 million assets. As the Supreme Court noted in *Ferdon v. WCFP*, 2005 WI 125, ¶158 "The Fund has flourished both with and without a cap. If the amount of the cap did not impact the Fund's fiscal stability and cash flow in any appreciable manner when no caps existed or when a $1,000,000 cap existed, then the rational basis standard requires more to justify the $350,000 cap as rationally related to the Fund's fiscal condition."

Conclusion

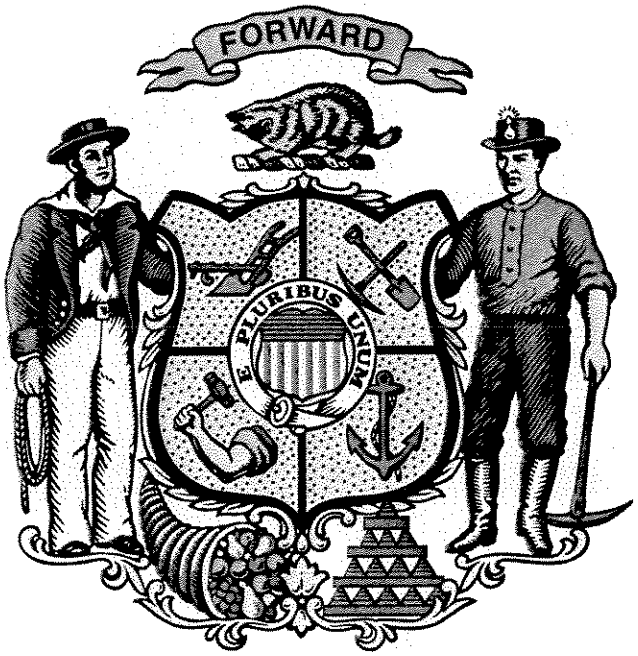
The ominous implications for the Constitutional rights of Wisconsin citizens—particularly injured patients—were minimized during the legislative debate in 1995 that imposed the cap on pain and suffering in medical malpractice cases. Instead, advocates of the cap argued that this loss of legal access for a relative few would be far outweighed through a tradeoff for broader public benefits — lower health care costs, more doctors in underserved areas and a solvent and stabilized Fund for injured patients and their families.

In practice over the past decade, the tradeoff of legal rights for public benefits proved to be disastrous. While our legal rights certainly were diminished, the promised benefits have never appeared. Wisconsin does not have lower health care costs, doctors are still not going to underserved areas and the Fund was never in jeopardy, it had been in surplus since 1990, the year the $1 million cap expired.

The Legislature is following down the same trail again to impose a cap the attempts to ask the most severely injured patients and their families of severely injured patients to bear the burden of "fixing" the legal malpractice system alone. That is neither fair nor just.

Caps are a barrier to the courthouse for injured patients and their families and strike at the very heart of the civil justice system. It deprives juries of their constitutional mandate to do *justice* in individual cases. You are once again tilting the scales of justice in Wisconsin against severely injured patients and their families in favor of health care providers and their insurance companies.

We believe that is not only immoral, but unconstitutional.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Hospital Sisters
Health System

Belleville, IL
St. Elizabeth's Hospital

Breese, IL
St. Joseph's Hospital

Decatur, IL
St. Mary's Hospital

Effingham, IL
St. Anthony's Memorial Hospital

Highland, IL
St. Joseph's Hospital

Litchfield, IL
St. Francis Hospital

Springfield, IL
St. John's Hospital

Streator, IL
St. Mary's Hospital

Chippewa Falls, WI
St. Joseph's Hospital

Eau Claire, WI
Sacred Heart Hospital

Green Bay, WI
St. Mary's Hospital Medical Center
St. Vincent Hospital

Sheboygan, WI
St. Nicholas Hospital

My name is Sister Jomary Trstensky and I am President of Hospital Sisters Health System, a multi-hospital system located in Springfield, Illinois with eight hospitals in Illinois and five hospitals inWisconsin. Our organization has been involved in active health ministry in Illinois and Wisconsin since 1875. We constitute a tightly managed regional system of acute care hospitals. (Slide 1)

In Wisconsin we operate the following hospitals: Sacred Heart Hospital- Eau Claire, St. Joseph's Hospital – Chippewa Falls; St. Vincent Hospital – Green Bay; St. Mary's Hospital Medical Center – Green Bay; and St. Nicholas Hospital – Sheboygan. As a demonstration of our collective presence in Wisconsin, I offer some statistics from our recent audited financial statements showing evidence of the work we do with the people of this fine state.(Slide 2) On an annual basis we treat 34,000 people in our hospitals and another 456,277 as outpatients. We believe that we are, not only essential providers of state of the art health care to citizens in these communities, but also significant economic contributors because of the dollars flowing into the four communities by virtue of our hospital payrolls which came to $213,000,000 last year. (Also Slide2) We take pride in being good citizens as well as good healthcare providers.

What I have to share today is a tale of two states: Illinois and Wisconsin.(Slide 3). Our two-state location gives us a unique opportunity to compare things, in this case, medical malpractice expense for the hospitals. I present myself, not as the accounting wizard or an insurance professional, but as a steward of important resources put at our disposal for the care of people who come to us.

P.O. Box 19456 • Springfield, Illinois 62794-9456
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Because Wisconsin has had a limit on pain-and-suffering damages and Illinois has not, the two states have been a case study on controlled versus uncontrolled liability costs.

(Slide 4) Wisconsin hospitals have purchased primary coverage from WHKLIP or form commercial companies for the past 20 years. Excess coverage comes from the Patient Compensation Fund. Illinois, because of unfavorable insurance markets, has been self-insured for primary coverage and then protected by a purchased excess policy. (Slide 5)
Using audited data for calendar year 2005 we are able to show that Illinois costs exceed Wisconsin's costs by a factor of 3.5 to 1 on an adjusted patient day basis. If we adjust this to add the WHCLIP Rebates, the picture is even more dramatic, 4.2 – 1. It costs Illinois $35.63 per adjusted occupied bed per day to obtain medical liability coverage. The cost to Wisconsin is $8.41 per adjusted bed per day. These expenses do not include physician insurance policies, since our hospitals do not own or employ physicians. There is no plausible reason for this disparity other than the rational control in Wisconsin and the absence of that control in Illinois. The money saved in Wisconsin has been used for the development of new programs and services as well as new technology for our five Wisconsin hospitals. On the other hand, the extra expense in Illinois has been passed on to those who pay for health care, creating an extra burden.

My remarks are limited to hospital medical liability expense, but physicians have been

impacted by this phenomenon, so much so that Illinois has experienced an exodus of physicians from communities where their services are needed. For the sake of credibility, I limit my comments to the experiences of my own hospitals.

Because of the large expense associated with medical liability coverage for physicians, insurance companies have refused to write policies for doctors or have increased premiums beyond the doctors' ability to pay. (Slide 6) Doctors have left Illinois, moving to friendly markets.

A single hospital near the Missouri border in downstate Illinois, as of December, 2004, lost 30 physicians (average age 46) to this crisis. The hospital, very similar in size to St. Vincent Hospital in Green Bay, lost 1700 inpatient admissions, 12,000 outpatient admissions, 4000 surgical procedures, and $18 million dollars in revenue because of the defection of these 30 physicians. These doctors crossed the boundaries of primary care and all specialty services. Their stated reasons for leaving were: excessive premium increases or cessation of coverage entirely, coupled with the added threat of escalating tail coverage when they found an insurance company to cover them. This may sound like a problem of the insurance industry, but the root cause is excessive awards, excessive numbers of settlements which give rise to anxiety among insurers and among practitioners.

To clarify, I have said that our Illinois hospitals self-fund medical liability insurance. Because of the large awards given in court, organizations like ours have to make a calculated guess as to the merit of settling out of court versus trying the case. In many cases we opt for settlement in order to limit litigation costs. Therefore, one has to consider settlement costs as well as award costs in calculating the liability expense.

This tale of two States has direct bearing on AB 766 that recently received the support of the Assembly. I am here today to ask that you do your part to restore Wisconsin to a stable

medical liability environment. I believe that if providers make a mistake, we should be held accountable. People who feel victimized should have an avenue of recourse. But it must be reasonable. Unless a cap is reinstated on noneconomic damages, Wisconsin will experience what Illinois has endured. We used this same information in Illinois to help convince legislators there that some kind of control is necessary. We used Wisconsin's experience as a great success story! Unless action is taken to restore caps, there will be an increase in the cost of conducting business in Wisconsin, there will be a loss of needed physicians, access to care will suffer, employee compensation will be negatively affected, and funds will be diverted from new investments into paying for insurance.

Thank you for giving me the opportunity to share our story.

1

Wisconsin Legislative Hearing

October 27, 2005

Sr. Jomary Trstensky, President
Hospital Sisters Health System

2

HSHS Statistics

- Wisconsin – FYE 6/30/2005

- Salaries	$213,000,000
- Benefits	$ 63,000,000
- Hospital admissions	34,201
- Outpatient visits	456,277

3

Hospital Sisters Health System

- Two-state System
  - Wisconsin – 5 Hospitals
  - Illinois – 8 Hospitals

Provides an opportunity to compare medical malpractice cost and administration between two states.

4

General & Professional Liability Insurance

- Wisconsin hospitals have purchased primary coverage from WHCLIP or from commercial insurance company for the past 20 years. Excess malpractice coverage comes from Patient Compensation Fund.
- In Illinois, unfavorable insurance markets led us to self-insure the primary coverage and then purchase excess coverage for medical malpractice.

5

HSHS Results

- Cost per adjusted occupied bed
  - Illinois $35.63
  - Wisconsin $10.18
    (3.5 to 1)
- Cost adjusted for 2005 WHCLIP Rebates
  - Illinois $35.63
  - Wisconsin $ 8.41
    (4.2 to 1)

Costs are for calendar year 2005. In each state costs include general liability and professional malpractice insurance costs. General liability is a small portion of the total cost.

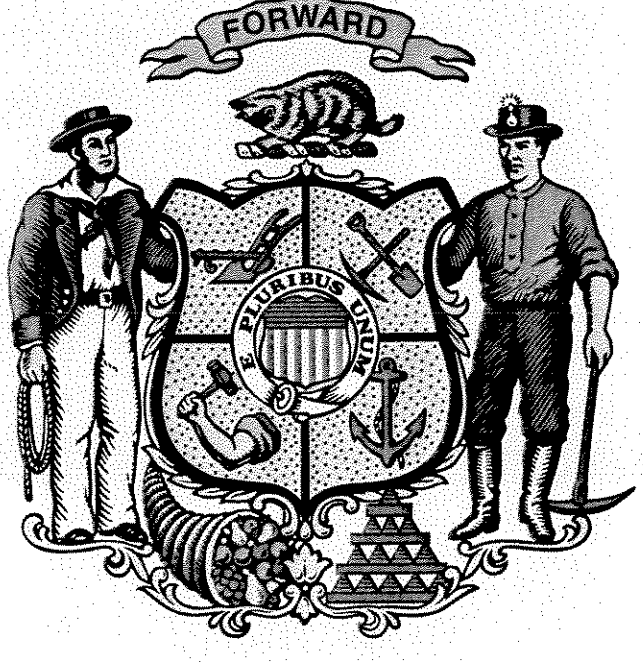
6

Doctors Have Left Illinois

Belleville – December 2004

Loss of 30 physicians
- 1700 inpatient admissions
- 12,000 outpatient admissions
- 4000 surgical procedures
- $18 million in revenue

Decreased access to critical services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WISCONSIN LEGISLATIVE COUNCIL
AMENDMENT MEMO

2005 Assembly Bill 764	Assembly Substitute Amendment 1
Memo published: October 21, 2005	*Contact*: Joyce L. Kiel, Senior Staff Attorney (266-3137)

Current statutes provide that, in a medical malpractice case, evidence of any compensation for bodily injury received by a plaintiff from a source other than the defendant (that is, from a collateral source) to compensate the claimant for injury is admissible in court. [s. 893.55 (7), Stats.] The Wisconsin Supreme Court recently held that if such evidence is admitted, then the injured party's obligations of subrogation or reimbursement to the collateral source (often a health insurer, an employer's self-funded health care plan, or a governmental plan providing health care coverage such as Medicare) also must be allowed as evidence. The court further held that evidence of collateral source payments for medical services could ***not*** be used to reduce the damage award for medical services in a medical malpractice case, even though that evidence could be used to determine the reasonable value of medical services.

2005 Assembly Bill 764 would codify the court's holding that the injured party's obligations of subrogation or reimbursement to the collateral source for its payments is admissible evidence in a medical malpractice case.

However, the bill would overturn the court's holding which prohibits a reduction in the amount of a medical malpractice damage award based on evidence of a collateral source payment. Specifically, the bill provides that if medical malpractice did occur, the finder of fact (the jury in a jury trial; the judge in a bench trial) must determine:

1. The amount provided from collateral sources to compensate the claimant for injury or death resulting from the medical malpractice; and

2. The amount that the claimant is obligated to reimburse the collateral sources for such compensation.

The bill then requires the court to subtract the amount determined under item 2. from the amount determined under item 1. and then reduce the amount of damages awarded in the medical malpractice case by that difference.

The bill would apply to medical malpractice acts or omissions that occur on or after the effective date of the bill.

One East Main Street, Suite 401 • P.O. Box 2536 • Madison, WI 53701-2536
(608) 266-1304 • Fax: (608) 266-3830 • Email: leg.council@legis.state.wi.us
http://www.legis.state.wi.us/lc

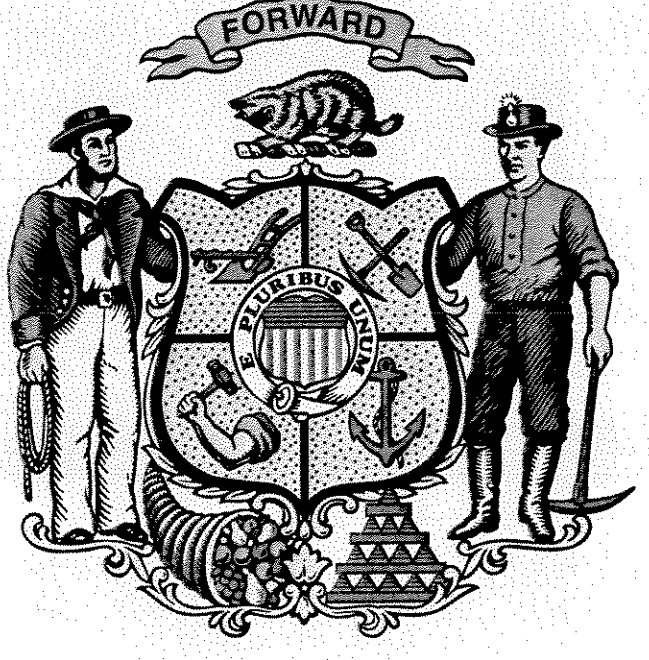
Assembly Substitute Amendment 1 to the bill makes the following changes to the bill:

- While the bill refers to collateral source payments as compensation for bodily injury or death, the substitute amendment deletes the references to death. Thus, the amended bill's provisions refer only to collateral source payments as compensation for bodily injury.
- The substitute amendment changes item 2., above, to refer to the claimant's legal obligation to pay the collateral source through subrogation or by reimbursement. The bill referred only to reimbursement in item 2., above. (This change makes the amended bill internally consistent as the proposed change to s. 893.55 (7), Stats., refers to the person's obligations of both subrogation or reimbursement.)

Legislative History

Assembly Substitute Amendment 1 to the bill was offered by the Assembly Committee on Insurance which then recommended adoption of the amendment on a vote of Ayes, 9; Noes, 6. The committee recommended the bill, as amended, for passage on a vote of Ayes, 9; Noes, 6.

JLK:rv:ksm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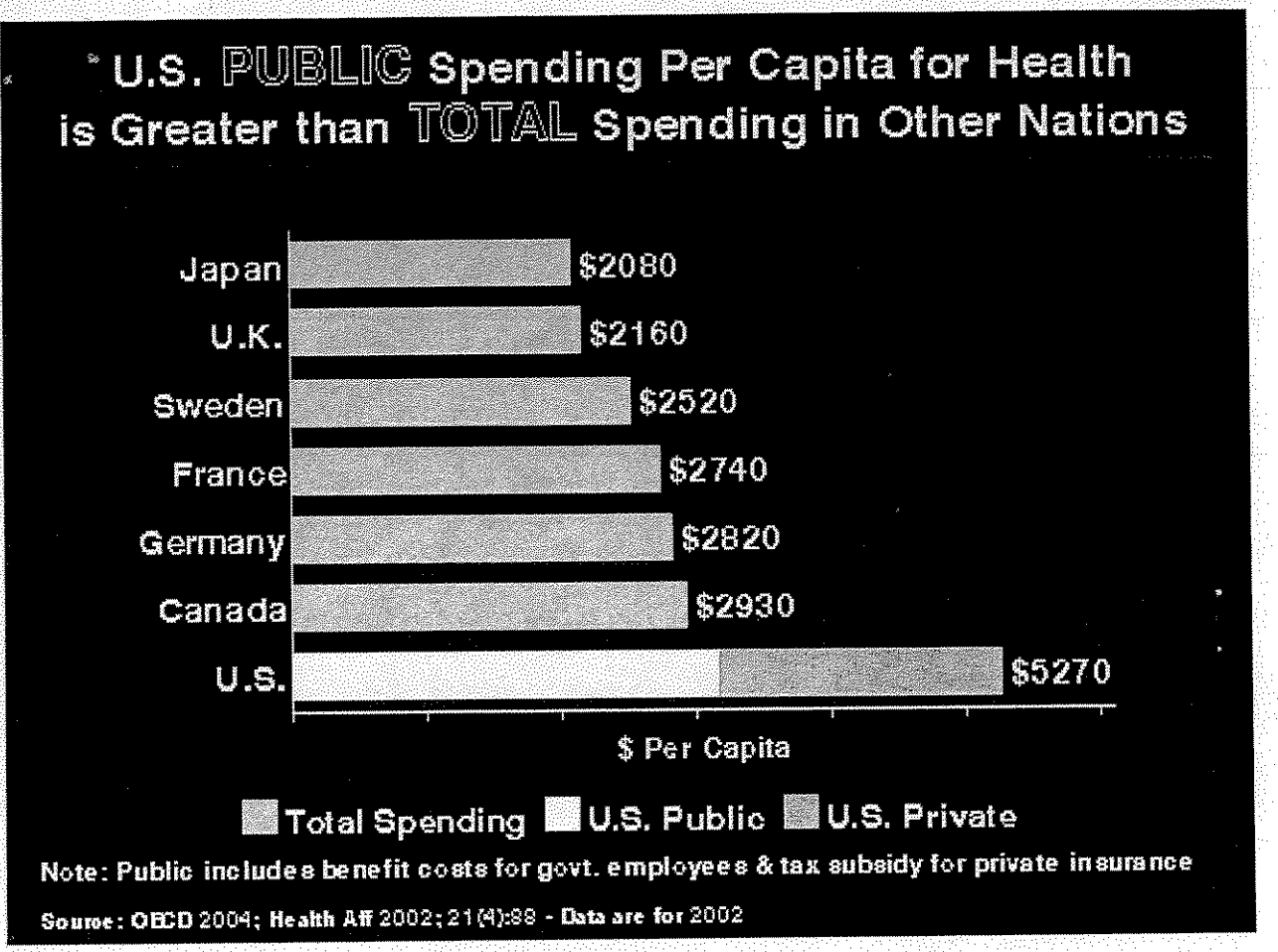
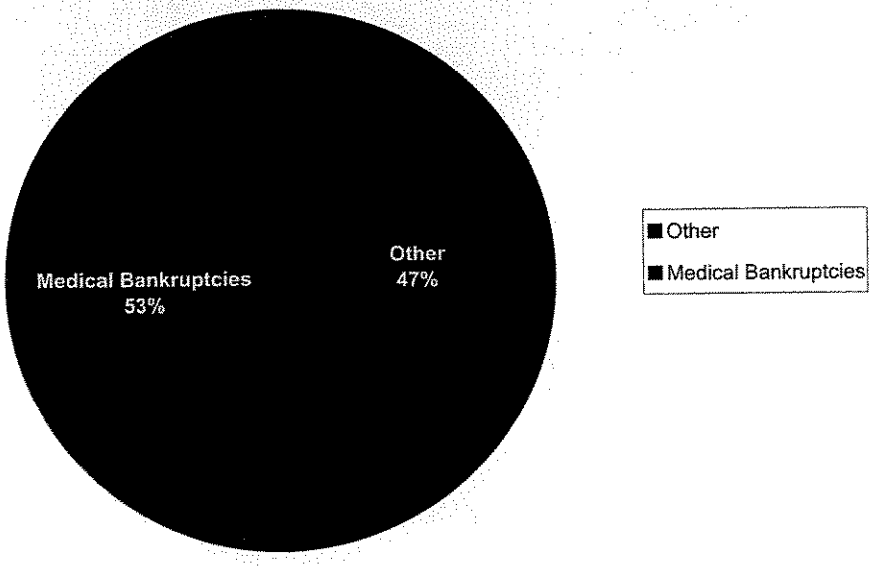
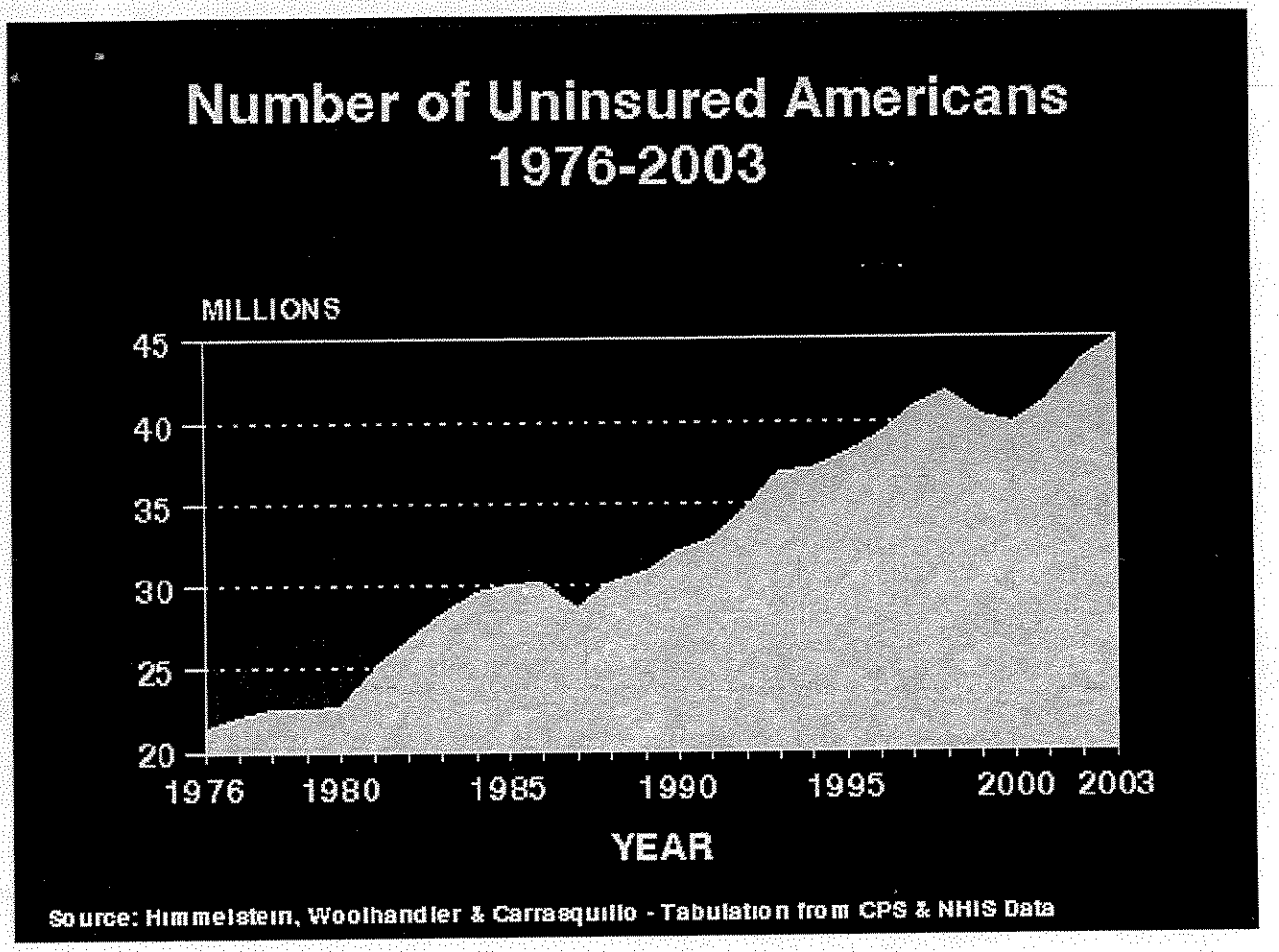


Medical Bankruptcies

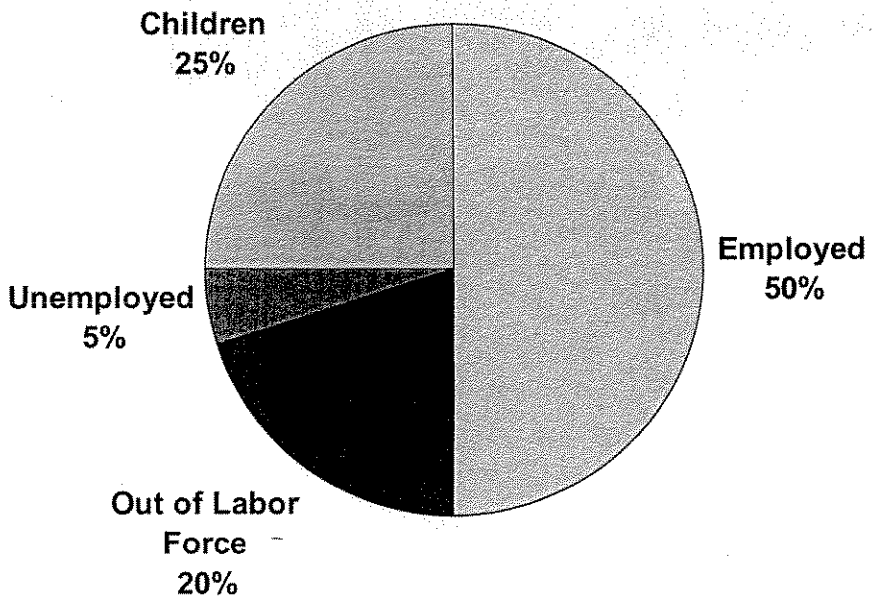
(As a percentage of Total Bankruptcies 2001)



"Illness and Injury as Contributors to Bankruptcy," Himmelstein et al, *Health Affairs* Web Exclusive, Februrary 2, 2005.

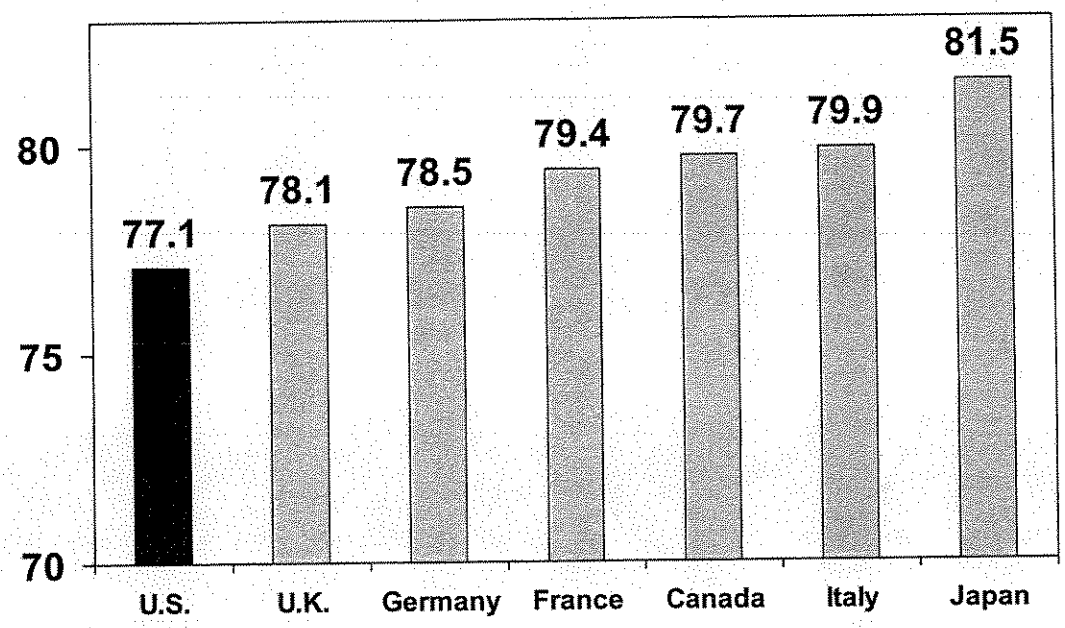


Who are the Uninsured?



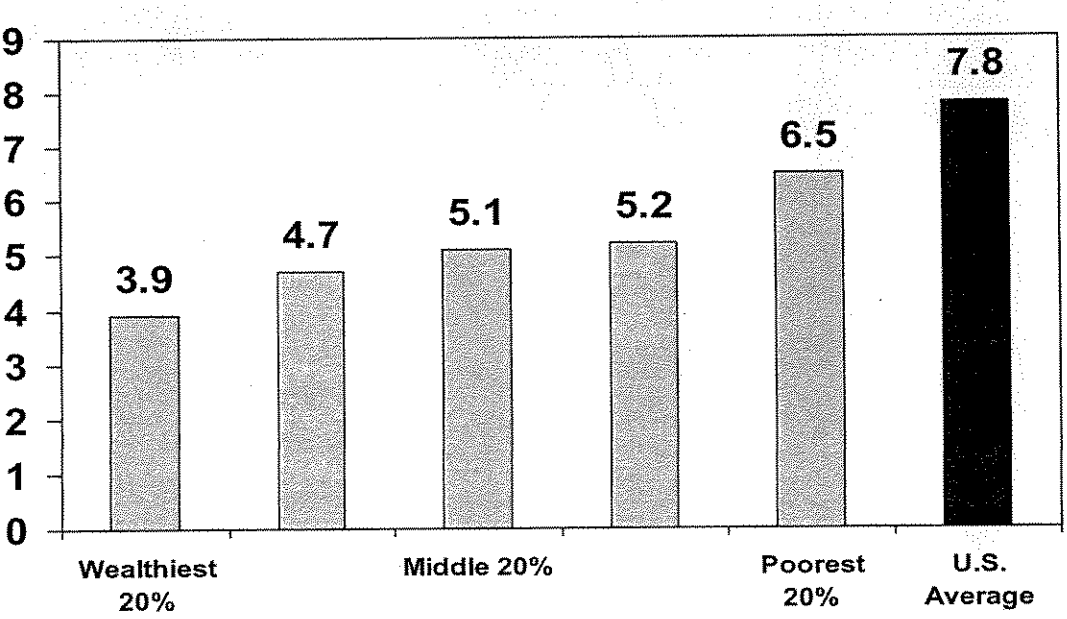
Current Population Statistics, 1999

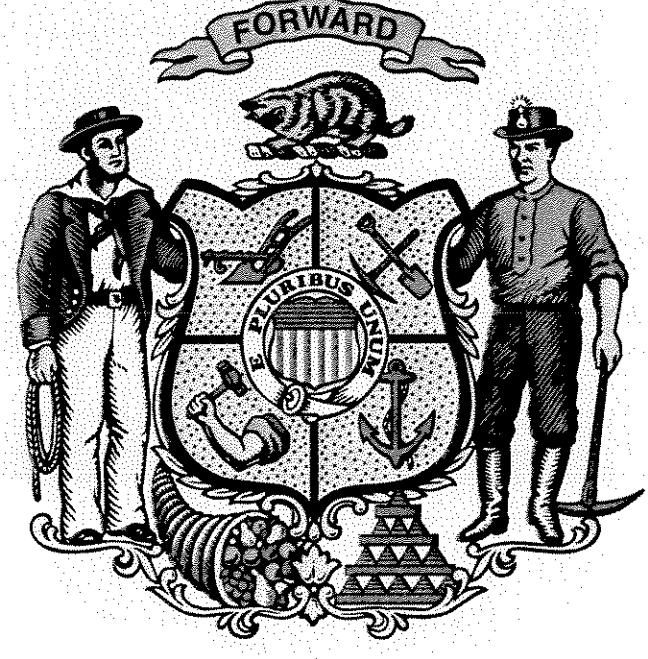
Life Expectancy



OECD, 2004, (2001 Data)

Infant Deaths by Income

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Tap the Power

SEP 01 2005

Knowledge is Power

These publications are available from the Wisconsin Legislature's Theobald Legislative Library

Medical Malpractice

Compiled by Arden Rice, Updated September 2005

http://www.legis.state.wi.us/lrb/pubs/tapthepower.htm

The Wisconsin Supreme Court recently struck down the constitutionality of Wisconsin's cap on noneconomic damages. This bibliography focuses on nationwide reforms and research findings on medical liability published since the December 2003 *Tap the Power* bibliography was released.

***Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care* / U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, March 3, 2003. (614.230/X4)** Examines the impact of increasing premiums on physicians' ability to practice medicine and explores various mechanisms for medical personnel to report errors without fear of litigation. http://aspe.hhs.gov/daltcp/reports-a.shtml#DALTCP31

***An Audit, Injured Patients and Families Compensation Fund, Office of the Commissioner of Insurance* / Wisconsin Legislative Audit Bureau, 2004. (614.230/W7b1)** This mandated report investigates the financial solvency of the fund. Previous audits from 2001 and 1998 are available under the former name "Patients Compensation Fund."
www.legis.state.wi.us/lab/reports/04-12Highlights.htm

***Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System* / U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, July 25, 2002. (614.230/X3)** Argues that medical malpractice insurance rates threaten access to care in many areas of the country and that inflated health costs are a result of "defensive medicine" practices by physicians intimidated by the threat of malpractice suits. http://aspe.hhs.gov/daltcp/reports-c.shtml#DALTCP25

***Containing Medical Malpractice Costs: Recent State Actions* / National Governors' Association Center for Best Practices, 2005. (614.230/N21a)** Updates a 2002 NGA brief on tactics used by states to mitigate the effects of rising malpractice insurance rates.
www.nga.org/Files/pdf/0507MALPRACTICECOSTS.PDF

***Ferdon v. Wisconsin Patients Compensation Fund (Medical Malpractice Liability Cap)* / Wisconsin Legislative Council , July 2005. (Information Memorandum 05-1). (LegisCl/2005-2007/i/05-1) (noncirculating)** Summarizes the recent Wisconsin Supreme Court case challenging the noneconomic damage caps imposed by the fund.
www.legis.state.wi.us/lc/2_PUBLICATIONS/Other%20Publications/Reports%20By%20Subject/Health/IM05_01.pdf

***Final Report on the Feasibility of an Ohio Patient Compensation Fund* / Pinnacle Actuarial Resources, Inc., May 2003. (614.230/Oh3)** Compares and contrasts the administrative and fiscal organization of PCFs in a dozen states including Wisconsin.
www.ohioinsurance.gov/Documents/05-01-03FinalReport.pdf

***Justice Capped: Tilting the Scales of Justice Against Injured Patients and Their Families: A 10-Year Review of Wisconsin's Cap On Pain and Suffering* / Wisconsin Citizen Action & Wisconsin Academy of Trial Lawyers, 2005. (614.230/W751a)** Argues that the cap discriminates against those gravely harmed by medical malpractice and does not reduce health care costs or affect the number physicians practicing in Wisconsin.
www.watl.org/watl__main_frame.htm

"Medical Liability: Beyond Caps" / *Health Affairs*, July/August 2004. (614.23/P94/2004/v.23/no.4) Contains six feature articles on medical malpractice, including "Are Damages Caps Regressive? A Study of Malpractice Jury Verdicts in California".

***Medical Liability Reform – Now! A Compendium of Facts Supporting Medical Liability Reform and Debunking Arguments Against Reform* / American Medical Association, 2005. (614.230/Am3b)** Detailed report demonstrating the impact of medical malpractice lawsuits on health care delivery.
www.ama-assn.org/ama1/pub/upload/mm/-1/mlrnowjune14 2005.pdf

"Medical Malpractice" / Arden Rice, Wisconsin Legislative Reference Bureau, *Tap the Power*, December 2003. (LRB/t) (noncirculating) A previous edition of this bibliography containing additional print and electronic resources.
www.legis.state.wi.us/lrb/pubs/ttp/ttp-12-2003.html

"Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms" / *Health Affairs* (Web Exclusives), 2004. (614.23/P94a/2004/Jan-June) Investigates the extent to which rising premiums are associated with increases in claims and considers whether tort reform is more than a stop-gap solution to a flawed medical liability insurance system.
www.healthaffairs.org/WebExclusives.php

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Medical Malpractice
Continued

***Medical Malpractice: Implications of Rising Premiums on Access to Health Care* / U.S. General Accounting Office, August 2003. (614.230/X7/pt.1)** Investigates whether "defensive medical practices" are inflating the cost of health care and how tort reform in certain states has impacted insurance premiums.
www.gao.gov/new.items/d03836.pdf

***Medical Malpractice Insurance Report: A Study of Market Conditions and Potential Solutions to the Recent Crisis* / National Association of Insurance Commissioners, 2004. (614.230/N213)**
www.naic.org/models_papers/papers/MMP-OP-04-EL.pdf

***Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages* / Congressional Research Service, updated April 11, 2005. (CRS Reports). (614.230/X8)** Outlines pro and con arguments for the provisions included in 2003 H.R. 5 and H.R. 4280 relating to caps on damages, the collateral source rule, joint liability, and lawyer's contingency fees. The report also contains a table showing the caps on punitive and noneconomic damages for all fifty states.
http://digital.library.unt.edu/govdocs/crs//data/2005/upl-meta-crs-6285/RL31692_2005Apr11.pdf

***Public Medical Malpractice Insurance* / Frank A. Sloan, Pew Project on Medical Liability in Pennsylvania, 2004. (614.230/P46)** Examines the pros and cons of implementing various government interventions adopted to alleviate the malpractice insurance crisis.
http://medliabilitypa.org/research/files/sloan0304.pdf

***Report on the Impact of Act 10* / Wisconsin Office of the Commissioner of Insurance, 1997-2005. (614.230/W7c4)** This biennial report examines the number of health care providers practicing in Wisconsin, the fees that health care providers pay under s. 655.27 (3), and the premiums that health care providers pay for health care liability insurance.

***Resolving the Medical Malpractice Crisis: Fairness Considerations* / Maxwell J. Mehlman, Pew Project on Medical Liability in Pennsylvania, 2003. (614.230/P94b)** Considers the desired outcome of malpractice trials and insurance programs in terms of fair and consistent treatment of victims, medical professionals, and the public's overall access to health care.
http://medliabilitypa.org/research/mehlman0603/MehlmanReport.pdf

Related Web Sites:

www.abanews.org/issues/medmal.html – American Bar Association

www.ama-assn.org/ama/pub/category/7861.html – American Medical Association – Medical Liability Reform

www.hcla.org – Health Coalition on Liability and Access

www.ncsl.org/standcomm/sclaw/medmaloverview.htm – NCSL's Medical Malpractice Tort Reform Committee

www.rwjf.org/reports/npreports/impacs.htm – Robert Wood Johnson Foundation: Improving Malpractice Prevention and Compensation Programs

http://medliabilitypa.org/ – Project on Medical Liability in Pennsylvania funded by the Pew Charitable Trusts

State Patients Compensation Funds:

www.in.gov/idoi/medmal – Indiana

www.hcsf.org – Kansas Health Care Stabilization Fund

www.lapcf.state.la.us – Louisiana

www.doi.ne.gov/medmal/index.htm – Nebraska

Reform Efforts and Studies From Other States:

www.cga.ct.gov/olr/medicalmalpracticeER.asp – Connecticut – Lists over 50 reports on medical malpractice written by the Office of Legislative Research since 2002.

www.unf.edu/thefloridacenter/Files/Medical%20Malpractice%20Update.pdf – Florida

http://insurance.mo.gov/aboutMDI/issues/medmal – Missouri

www.leg.state.nv.us/lcb/research/library/BackBurner.cfm – Nevada

www.state.nj.us/dobi/drcorner.htm – New Jersey

http://jsg.legis.state.pa.us/Med%20Mal.HTML – Pennsylvania – Report of the Advisory Committee on Medical Professional Liability

Clippings: (Noncirculating; available for use in the library; clippings prior to 1981 are on microfiche)

- Physicians (malpractice): 614.230/M29Z